UNIVERSITY OF
TORONTO
FACULTY OF LAW

THE LAW OF MENTAL HEALTH

Volume 1

Joaquin Zuckerberg

Winter 2008

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Part 1

Week 1(Jan. 7): General Introduction

No Readings Assigned

Week 2 (Jan. 14): Overview of the Mental Health System

Week 3 (Jan. 21): Capacity and Consent

Week 4 (Jan. 28): Substitute Decision Making

Week 5 (Feb. 4): Property Guardianship (Saara Chetner)

Week 6 (Feb. 11): Research, Organ and Tissue Transplantation and Sterilization Involving the Incapable Person (Bernard Starkman)

Week 7 (Feb. 25): Civil Commitment - Part 1

Part 2

Feb. 29 (FA3 - 2.10 to 4.00 pm): Make Up Class for Week 12 - Mental Health and the Criminal Justice System (Janet Leiper)

Week 8 (March 3): Civil Commitment - Part 2

March 7(FA3 - 2.10 - 4.00 pm): Make Up Class for Week 13 - International Human Rights and Mental Health Law

Required Reading

Week 9 (March 10): Mental Health Courts, Canadian Mental Health Commission and Mental Health Tribunals (joint session with Hon. Edward Ormston)

- Canadian Mental Health Commission's website, http://www.mentalhealthcommission.ca. Please visit the website to get a basic understanding of what the background to and Mandate of the Commission
- Consent and Capacity Board's website, www.ccboard.on.ca. Please visit the website to familiarize yourselves with the work of the Board
- *Health Care Consent Act*, Part V ..... See Appendix
- Carney, Terry and Tait, David, "Guardianship Dilemmas and Care of the Aged", 13 *Sidney L. Review* 61 1991, pp. 70-76 918
- Rees, Neil, "International Human Rights Obligations and Mental Health Review Tribunals, 10 *Psychiatry Psychol. & L.* 33 2003 942

Week 10: Privacy and Mental Health (Patrick Hawkins)

Required Reading

- CLASP for Credit Project: Submissions and Recommendations to Reform the Current Toronto Police Service Policy on Retention of Detentions Under the *Mental Health Act* 953
- Handouts will be provided before the class

Week 11 (March 24): Legal Representation of Mentally Ill Patients and Health Practitioners (Janice Blackburn and Anita Szigeti)

- Health Care Consent Act, s.81 ..... See Appendix
- Perlin, Michael, "The Role and Significance of Counsel," 42 San Diego L. Review 739 2005 967
- Legal Aid Ontario, "Consent and Capacity Panel Standards," at http://www.legalaid.on.ca/en/info/panel_standards.asp 988
- Tremblay, Paul A., "On Persuasion and Paternalism: Lawyer Decision making and the Questionably Competent Client," 1987 *Utah L. Rev.* 515 1987 992
- Szigeti, Anita, *Representing a Client Who Has a Mental Health Issue before the CCB*, October, 2007 1062

Appendixes

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Introduction to Capacity and Consent

Joaquin Zuckerberg, Legal Counsel, CCB

What is capacity? What does it mean? How do you define it? How do you measure it? Capacity, in the treatment context, is defined in section 4(1) of the *HCCA*.

If you read the definition of capacity you will see that it can be broken down into two parts. The CCB shall confirm the finding of incapacity if the health practitioner proves on the balance of probabilities that the patient fails either one or both parts of the test.

The first part of the test is the ability to "understand the information relevant to making a decision about the treatment". Is the patient suffering from some neurological or mental condition such that he or she cannot, on some basic cognitive level, understand the relevant information? This could be caused by any number of things from being in a coma, to having neurological deficits as a result of having suffered a stroke, to suffering from a classic psychiatric illness such as schizophrenia, to being developmentally delayed. Note that "mental disorder" is not a factor.

The second part of the test is the ability to "appreciate the reasonably foreseeable consequences of a decision or a lack of decision". In other words, can the patient relate the information about the treatment to their own condition at that point in time? Do they appreciate the hoped-for benefits of the treatment?

Do they appreciate the possible risks and side effects of the treatment? The key is the ability to appreciate these things as it relates to them, and not in the abstract. Sometimes patients suffering from psychiatric illnesses can recite text and verse everything about the medications with which their psychiatrist wishes to treat them. They sound like pharmacists with their depth of knowledge. When you question them however about their own mental state, they will say that they are not suffering from any mental illness and therefore there is no possible benefit to be derived by them taking the medications in question. They may therefore be unable to relate the proposed treatment to their own

situation.

When discussing capacity it is crucial to remember the presumption of capacity in section 4(2) of the *Health Care Consent Act*, namely that every person is presumed to be capable with respect to treatment. While this may seem obvious, there are examples where the health care professional will, without doing any capacity assessment, assume a patient to be not capable of consenting to treatment merely because of some fact like the patient is very old, has difficulty speaking English, is non-cooperative or does not agree with the proposed treatment. None of these factors, in and of itself, is determinative of whether a patient is or is not capable with respect to his or her treatment. A proper assessment and finding of incapacity must be made first. The starting point for any assessment is that the patient is presumed to be capable, and this presumption must be rebutted if a finding of incapacity is to be made.

A key principle in any discussion about capacity is that capacity is decision/issue and time *specific*.

Incapacity is not a global concept. Unless a person is in a coma, he or she may be quite capable of consenting to many treatments, and incapable regarding others. For example, a person suffering from schizophrenia may, as a result of suffering from this illness, be incapable of consenting to the taking of neuroleptic medications for his or her schizophrenia, but that same person may be capable of consenting to taking Tylenol for his or her headache, or medications for his or her high blood pressure. It is wrong to assume that someone is incapable of consenting to all treatments if they are incapable of consenting to any given treatment.

Another situation which sometimes arises is where a doctor determines a patient is incapable with respect to a specific medical treatment, consent is obtained from the substitute decision maker to that treatment, the treatment is given and then discharge planning takes place to place the patient in a nursing home. The discharge planning team assumes that the patient is incapable of consenting to his or her admission to a nursing

home.

This is wrong. Nobody made a finding of incapacity with respect to that patient's capacity to consent to admission to a nursing home. Incapacity to consent to a specific medical treatment is not linked to incapacity to consent to admission to a nursing home. These are totally distinct issues and require specific findings of incapacity in each case.

Capacity is also time specific. It can, and often does, fluctuate over time.

Another key principle when discussing capacity is the right of each person to make foolish decisions. Just because a patient does not consent to the treatment being proposed by the health practitioner does not, in and of itself, make that patient incapable with respect to that treatment. The patient may be quite capable but is refusing the treatment based upon factors such as his or her religious beliefs, moral values, cultural upbringing or a whole host of other reasons, logical or not. As long as the patient meets the test for capacity (i.e. the presumption of capacity has not been displaced), we have no right to impose the values and beliefs of what may very well be a significant majority of society upon that individual. Just because it seems so right and logical that a patient take a certain treatment, does not give anybody the right to impose that treatment. As long as you are capable, you have the absolute right to make a decision for yourself that the majority of society would view as wrong or even foolish.

For example, if a deeply religious person contracted some illness whose only known cure was to eat a type of food forbidden to be eaten by that person's religious beliefs (i.e. - beef to someone of the Hindu faith, or pork to someone of the Jewish or Muslim faith), and the doctor said to him or her that the doctor would guarantee them a 100% recovery if they ate that food everyday and a 100% certainty of death if they did not, and if that person then said that they could not, due to their religious beliefs, eat that food, would that person be incapable with respect to that proposed treatment? Not necessarily assuming that they are able to. They understand fully the information that their doctor is providing to them about the proposed treatment, and to appreciate that they will die by

not eating that food, they are capable to decide to refuse it. You might think that such a decision was foolish, but that is irrelevant to the question of capacity.

A more common example comes from a real life scenario that will occur more as our population ages. A senior citizen has lived independently for many years. Perhaps they had a falling out with their family many years ago and have lost contact with their family. Perhaps they are the last surviving member of their family. Sometimes they even have family but refuse to listen to what their family is saying. Over time this person has grown more frail. Their home is in greater disarray. It is becoming increasingly difficult for them to live alone at home. Then something catastrophic happens that lands them in hospital. Perhaps they fell at home and broke their hip. The surgeon replaced their hip in hospital. The urgent medical condition has been resolved. Now it is time to go home, and the social worker gets involved in the discharge planning.

It's now apparent to everybody except the patient that he or she cannot live safely at home. Community Care Access cannot provide more than a couple of hours a day of Home Care visits. The individual does not have the financial resources to pay for private home care. The hospital administration wants the individual out of the hospital because it is far too expensive to keep them in hospital and they need the hospital bed for other patients. The best thing to do would be to arrange for this person to go and live permanently in a nursing home. The individual absolutely refuses. They value their independence and autonomy above all else and want to go home. They say they are prepared to live with the consequences of that decision. The discharge planning team wants to do the "right" thing, which, they believe is to have the individual go live in a nursing home.

Is this person capable of consenting to his or her admission to a nursing home? Perhaps, perhaps not. It all depends on the evidence. If they are capable, then they have the right to make a bad decision. If they are not capable, then the consent of the substitute decision-maker must be obtained to admit the individual to a nursing home, if the substitute decision-maker is prepared to provide such consent.

Note that capacity to consent is a *decisional,* not a *functional* test. The legislation is not concerned with the person's ability to actually live at home, but the ability to make the decision.

A very important word in the capacity definition is "ability." A person is capable if he or she has the *ability* to understand the information and the *ability* to appreciate the reasonably foreseeable consequences of giving or refusing consent. The law does not require actual understanding or appreciation. As Justice Major said in *Starson,* there are many reasons why a capable person may not have actual understanding or appreciation, perhaps something as simple as the fact that no one explained the relevant information.

So, in assessing or reviewing capacity, there are four things to determine:

1. What decision or decisions does the finding of incapacity relate to?
2. What is the information relevant to this person's decision to give or refuse consent?
3. Does the person have the ability to understand that information?
4. What are the reasonably foreseeable consequences of giving or refusing consent?
5. Does the person have the ability to appreciate them?

INTRODUCTION TO THE INVOLUNTARY ADMISSION CRITERIA

JOAQUIN ZUCKERBERG, LEGAL COUNSEL, CCB

The Purpose of Section 20 of The Mental Health Act (the "*MHA*")

This section authorizes an attending physician to detain a person suffering mental disorder as an involuntary patient in a psychiatric facility *if and only if* the person meets the criteria of the legislation for detention *and* the physician has detained the person according to the correct procedure. The legislation balances various rights:

- the right of a person not to be arbitrarily detained;
- the right of a person suffering mental disorder to be protected from the mental and physical ravages of the illness; and
- the public's right to be protected from a person likely to cause serious bodily harm to another as a result of mental disorder.

Section 20 sets out two types of criteria an attending physician must meet before detention is valid:

- the substantive tests set out in subsections 20(1.1) or 20(5); and
- the procedural requirements, such as filing the Form 3 or 4 with the facility's officer in charge, set out in subsection 20(8).

Section 20(5) of the *MHA*

"Mental disorder"

Mental disorder is defined as "any disease or disability of the mind". This is a very broad definition. Note that the *MHA* does not say a mental disorder, but simply "mental disorder". A specific diagnosis is not mandatory, only a finding of some mental disorder. At the time of the hearing the doctor may only have a working diagnosis and not a final diagnosis.

"Likelihood"

Remember, the *MHA* does not require that an attending physician be certain that a particular harm will occur. Rather the *MHA* requires that the attending physician form an

opinion as to whether or not, as a result of mental disorder, one or more of the three criteria for involuntary admission is "likely" to occur unless the patient remains in the custody of the psychiatric facility. The Courts have held that "likely" means probable, not highly probable (nor possible). The legislation does not specify whether this is a long-term or short-term probability, and 'likelihood' might therefore be invoked for either kind. Likelihood need not be "imminent" (a former requirement which was removed from the MHA). However, some panels of the CCB have held that the event (e.g. harm, impairment, etc.) must happen within a reasonable time and that likelihood includes an element of proximity.

Courts have defined "serious bodily harm" as being "bodily harm that is somewhat more than trifling."[1] The CCB has traditionally referred to "physical impairment" as unintentional self-harm through an inability to care for oneself. It includes both physical impairment of the patient by his/her own acts and acting out "in such an aggressive and obnoxious way that [the patient] will invite harm at the hands of other people."

Keep in mind that the CCB does not necessarily have to confirm the patient's status as an involuntary patient based upon the Box A criteria set forth in the Certificate of Involuntary Admission or Certificate of Renewal that was signed by the physician. Rather, the Board has the jurisdiction to confirm a patient's involuntary status on any of the three Box A criteria, or for that matter on the Box B criteria. The Certificate in question may have been signed several days or perhaps even several weeks ago and the patient's mental condition may have changed since that time. A different criterion for involuntary admission may be justified at the time of the hearing.

Suitability for admission or continuation as a voluntary patient?

It is the patient's willingness to remain in the facility and willingness and ability to abide by the rules that determines suitability to be a voluntary patient.

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[1] Dayday v. MacEwan (Dist. Ct.) 62 O.R. (2d) 588.

Note that the legislation does not say "*unless the patient is willing to stay*" as a voluntary patient. It states that the patient has to be suitable as a voluntary patient, and suitability means something more that just a stated willingness to stay. Some patients who express a willingness to stay may still be unsuitable for voluntary status. For example their mood may be quite labile, and thus their willingness to stay voluntarily may change shortly. Or, the patient may be willing to remain in hospital but unwilling or unable to abide by hospital rules, such as not smoking in bed. It's important to look at the patient's past conduct in the current or previous similar admissions. Have they remained on a voluntary basis?

Informal status is defined in s. 1 of the MHA, and requires reference to s.24 of the *Health Care Consent Act*. It will rarely apply in these cases, but should nonetheless always be considered, as unsuitability for informal status is part of the legal test.

Section 20(1.1) of the *MHA*

Section 20(1.1) is longer and more complicated than Section 20(5). Some of the concepts and criteria that are introduced in Box B have been addressed in some Board cases:

- ✓ ***"has previously received treatment"*** What treatment must have been previously received? Does this even matter? Must the current treatment plan include the same or similar treatment, as previously received? A few Board decisions indicate that treatment need not have been received in the psychiatric facility in question, nor in any psychiatric facility at all, and that the treatment could have been received anywhere. Nothing in the legislation requires that the treatment now being administered or proposed be the same as the previous treatment.
- ✓ ***"for mental disorder"*** Again, as in the case of Section 20(5), it does not say a mental disorder, but rather only "mental disorder." A specific diagnosis is not mandatory, only a finding of some mental disorder.
- ✓ ***"of an ongoing or recurring nature"*** How long does someone have to have

been suffering from mental disorder for it to be "ongoing?" After how many days does a mental disorder become "ongoing?" Note that the word "or" is used and not the word "and." Thus the mental disorder could be either "ongoing" or "recurring" or both, but need not be both. Is the second episode of someone's mental disorder sufficient to qualify it as being "recurring?"

- ✓ ***"serious bodily harm to the person"*** This would appear to be the same as section 20(5)(i) which speaks of "serious bodily harm to the patient."
- ✓ ***"or to another person"*** This would appear to be the same as section 20(5)(ii) which speaks of "serious bodily harm to another person."
- ✓ ***"or substantial mental or physical deterioration of the person"*** This is new wording and is not found in section 20(5). What is the difference between "physical deterioration" and "physical impairment?" How much deterioration, (either mental or physical) qualifies as "substantial?"
- ✓ ***"or serious physical impairment of the person"*** This would appear to be the same as Section 20(5)(iii) which speaks of "serious physical impairment of the patient."
- ✓ ***"has shown clinical improvement as a result of the treatment"*** Is "clinical improvement" different than "improvement?" Must the "clinical improvement" have been in the psychiatric facility in question or in any psychiatric facility at all, or could it have been anywhere? Board Decisions indicate that "clinical improvement" is something that can be observed, discerned or measured. Physicians establish this in different fashions: Mr. X is still delusional, but no longer is all his behaviour governed by his delusions; Ms Y is still thought disordered, but now can focus her attention well enough to take part in a conversation.
- ✓ ***"the same mental disorder...or from a mental disorder that is similar to the previous one"*** Again, note that a precise diagnosis is unnecessary. Is it a valid objection to the Box B criteria that the patient was previously treated for alcoholism, but is now being treated for major depression?
- ✓ ***"given the person's history of mental disorder"*** Is the second episode of a someone's mental disorder sufficient to have a "history?"

- ✓ ***"current mental or physical condition"*** Note that the word "or" is used and not the word "and."
- ✓ ***"is likely to cause..."*** The same wording as contained in the latter part of subsection (a) is repeated again.
- ✓ ***"has been found incapable...of consenting to...treatment in a psychiatric facility"*** A formal finding of incapacity (as defined in section 4(1) of the *Health Care Consent Act*) must have been made by a health practitioner (but not necessary confirmed by the Board).
- ✓ ***"the consent of his or her decision-maker has been obtained"*** Note that the word "has" is used, and not the words "will be obtained" or "is being obtained." This appears, therefore, to be a condition precedent.
- ✓ ***"is not suitable for admission...as...voluntary patient"*** The same wording as contained in the latter part of subsection (a) is repeated again.

"Procedural" Requirements

Section 20(8) of the *MHA*: Review by Officer in Charge

- ✓ ***"the officer in charge or his delegate shall review"*** A delegate of the officer in charge may conduct the review required by the legislation. A number of Board decisions have held that the review is not intended to be a clinical review but rather a clerical review or proof-reading function, namely a review to ascertain whether the paperwork is done correctly.
- ✓ ***"forthwith following completion and filing"*** This provision must be taken to contemplate the possibility of some *brief* period of delay between the completion and filing and the review. Board decisions have stated that the test must be one of reasonableness under the particular circumstances of the case having particular regard to the rights of the patient and the overriding importance of following the procedures set out in the legislation.

Section 38 of the *MHA*: Provision of Notice and Rights Advice Promptly After the Issuance of the Certificate

- ✓ ***"the attending physician…shall promptly give the patient written notice…"***
- ✓ ***"the attending physician…shall promptly notify a rights adviser the patient written notice…"***
- ✓ ***"the rights adviser shall promptly meet with the patient…"***

Board decisions have stated that what the test for "promptly" must be one of reasonableness under the particular circumstances of the case having particular regard to the rights of the patient and the overriding importance of following the procedures set out in the legislation.